



# Provider User Manual

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# Introduction

The Kentucky Medicaid EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Background information and registration procedures follow, but **if you are ready to start your EHR registration, please see 'Registration for Eligible Providers' on page 12 and 'Registration for Eligible Hospitals' on page Error! Bookmark not defined..**

## Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>
- Kentucky State Medicaid HIT Plan (SMHP) Version 1.0 located at <http://chfs.ky.gov/dms/EHR.htm>
- Kentucky Medicaid HER Application Portal located at <https://apps4.chfs.ky.gov/kyslr/>
- Medicare and Medicaid Electronic Health records (HER) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at [http://healthit.hhs.gov/portal/server.pt/community/healthit\\_hhs\\_gov\\_\\_home/1204](http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204)

Two Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky EPs. The RECs provide a full range of assistance related to EHR selection and training and are listed below:

:

- **Northern/Northeastern Kentucky – Tri-State REC**  
**Website:** <http://www.healthbridge.org/rec/>  
**Phone:** 513-469-7222 x4 or 513-469-7230  
**E-mail:** [info@healthbridge.org](mailto:info@healthbridge.org)
- **Rest of Kentucky – Kentucky REC**  
**Website:** <http://www.ky-rec.org/>  
**Phone:** 888-KY-REC-EHR or 859-323-3090  
**E-mail:** [kyrec@uky.edu](mailto:kyrec@uky.edu)

## Revisions

- Original 12/29/2010
- Version 1.1, Revised 1/3/2011
- Version 1.2, Revised 1/6/2011
- Version 1.3, Revised 1/14/2011
- Version 1.4 Revised 1/18/2011
- Version 1.5 Revised 2/18/2011 (Application Release 1.3)
- Version 1.6 Revised 5/12/2011 (Application Release 1.4)
- Version 1.7 Revised 7/26/2011 (Optometrist)
- Version 1.8 Revised 8/5/2011 (Application Release 1.5)
- Version 1.9 Revised 1/13/2012 (Application Release 1.18)
- Version 1.91 Revised 2/3/2012 (Application Release 1.19)
- Version 2.0 Revised 2/15/2012 (Application Release 1.20)
- Version 2.1 Revised 5/14/2012 (Application Release 1.25)

## Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.hhs.gov>

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Kentucky Department for Medicaid Services (DMS) will work closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

## Eligibility

While EPs can begin the program in Calendar Year (CY) 2011, they must begin the program no later than CY 2016 and EHs must begin by Federal Fiscal year (FFY) 2016.

The first tier of provider eligibility for the Kentucky Medicaid EHR Incentive Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store does not correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following providers and hospitals are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Physicians = Any provider who has a Provider Type 64 and Specialty other than 345 (Pediatrics)
- Physician Assistant (practicing in a FQHC [Provider Type 31 and Specialty 80] or RHC [Provider Type 35] led by a Physician Assistant) = Any provider with a Provider Type 95 and Specialty other than 959 (PA Group). An FQHC or RHC is considered to be PA led in the following instances:
  - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
  - The PA is the clinical or medical director at a clinical site of the practice
  - The PA is the owner of the RHC
- Pediatrician = Any provider with a Provider Type 64 and Specialty 345
- Nurse Practitioner = Any provider with a Provider Type 78 and not Specialty 095 (CNM) or 789 (Nurse Practitioner Group)
- CNM = Any provider with a Provider Type 78 and Specialty 095
- Dentist = Any provider with a Provider Type 60 (Individual)
- Optometrist = Any provider with a Provider Type 77
- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

### Additional requirements for the EP

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based and must:

1. Meet one of the following patient volume criteria:
  - a. Have a minimum of 30 percent patient volume attributable to individuals receiving TXIX Medicaid funded services; or
  - b. Have a minimum 20 percent patient volume attributable to individuals receiving TXIX Medicaid funded services, **and** be a pediatrician; or
  - c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals.
2. Have no sanctions and/or exclusions.

An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the National Level Registry (NLR) and must match a TIN linked to the individual provider in DMS's system. This means the system will not be available to a provider for attestation from the time the contract is submitted for renewal until it has been approved by DMS.

## Additional requirements for the EH

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment and
  2. A children's hospital (exempt from meeting a patient volume threshold).
- Hospital-based providers are not eligible for the EHR incentive program.

**Note** also that some provider types who are eligible for the Medicare program, such as podiatrists and chiropractors, are not currently eligible for the Kentucky Medicaid EHR Incentive Program.

### Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume over Minimum 90-days	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC -30% "needy individual" patient volume threshold
Pediatricians	20%	
Dentists	30%	
Optometrist	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children's Hospital	Exception	

## Out-of-State Providers

The Kentucky Medicaid EHR Incentive Program welcomes any out-of-state provider to participate in this program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

## Establishing Patient Volume

A DMS provider must annually meet patient volume requirements of Kentucky's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP. All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on TXIX Medicaid and out-of-state Medicaid patients. The EHR statute allows for an EP practicing predominantly in an FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

## Patient Encounters Methodology

### Eligible Professionals:

- EPs (except those practicing predominantly in an FQHC/RHC) – to calculate TXIX Medicaid patient volume, an EP must divide:
  - The total TXIX Medicaid or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
  - The total patient encounters in the same 90-day period.
- EPs Practicing Predominantly in an FQHC/RHC – to calculate needy individual patient volume, an EP must divide:
  - The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
  - The total patient encounters in the same 90-day period.

### Definition of an Eligible Professional DMS Encounter

For purposes of calculating EP patient volume, a DMS encounter is defined as services rendered on any one day to an individual where TXIX DMS or another State's Medicaid program paid for

- Part or all of the service; or
- Part or all of their premiums, co-payments, and/or cost-sharing.

### Definition of a Needy Individual Encounter

For purposes of calculating patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Paid for by TXIX Medicaid or TXXI Children's Health Insurance Program funding including DMS, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Furnished by the provider as uncompensated care; or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

**Group practices** – Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;
- There is an auditable data source to support the clinic's or group practice's patient volume determination;
- All EPs in the group practice or clinic must use the same methodology for the payment year;
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

### Eligible Hospitals

To calculate TXIX DMS patient volume, an EH must divide:

- The total TXIX DMS and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year by:
- The total encounters in the same 90-day period.
  - Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period. *(Please note per CMS FAQ nursery days are excluded from inpatient bed days)*
  - An emergency department must be part of the hospital.

## Eligible Hospital DMS Encounter

For purposes of calculating eligible hospital patient volume, a DMS encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the emergency room where TXIX DMS or another state's Medicaid program paid for:

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

Exception – a children's hospital is not required to meet Medicaid patient volume requirements.

## Payment Methodology for EPs

The maximum incentive payment an EP could receive from Kentucky Medicaid equals \$63,750, over a period of six years, or \$42,500 for pediatricians with a 20-29 percent DMS patient volume as shown below.

Provider	EP	EP-Pediatrician
Patient Volume	30 Percent	20-29 Percent
Year 1	\$21,250	\$14,166.67
Year 2	8,500	5,666.67
Year 3	8,500	5,666.67
Year 4	8,500	5,666.67
Year 5	8,500	5,666.67
Year 6	8,500	5,666.65
<b>Total Incentive Payment</b>	<b>\$63,750</b>	<b>\$42,500</b>

Since pediatricians are qualified to participate in the Kentucky Medicaid EHR incentive program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

## Payments for Eligible Professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation National Level Repository (NLR). The TIN must be associated in the Kentucky MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated. EPs who assign payment to themselves (and not a group or clinic) will be required to provide DMS with updated information. Each EP must have a current DMS contract and be contracted for at least 90 days.

The Kentucky Medicaid EHR Incentive program does **not** include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully use certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may

begin receiving payments is 2016, and the last year the EP can receive payments is 2021

Currently, all providers are required to submit a valid NPI as a condition of DMS provider enrollment. Each EP or EH will be enrolled as a DMS provider and will therefore, without any change in process or system modification, meet the requirement to receive an NPI. DMS performs a manual NPPES search to validate NPIs during the enrollment process.

In the event DMS determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

The timeline for receiving incentive payments is illustrated below:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

## Payment Methodology for Eligible Hospitals

Statutory parameters placed on Kentucky Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children's hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Kentucky is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Kentucky Medicaid incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Kentucky MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

The Kentucky Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

$$EH\ Payment = Overall\ EHR\ Amount \times Medicaid\ Share$$

Where:

**Overall EHR Amount** = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

**Medicaid Share** = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

Kentucky intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Kentucky Medicaid payments. The reason for this approach is that most of Kentucky's numerous rural hospitals operate on a very thin margin and need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Kentucky has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Kentucky's cost report. Kentucky has received approval from CMS to use the Kentucky Medical Assistance Program (KMAP) disproportionate share form data in lieu of cost reports for this data. A standard questionnaire is used to determine the disproportionate share.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges— charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

## Provider Registration

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong.

EPs must select the Medicare or Medicaid's incentive program (a provider may switch from one to the other once during the incentive program prior to 2015). If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the KYSLR system to attest for Kentucky's Medicaid EHR Incentive Program. DMS will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, NLR will be notified by DMS that a payment has been made.

## Provider Attestation Process and Validation

DMS will utilize the secure KYSLR system to house the attestation system. The link will only be visible to providers whose type in the MMIS system matches an EHR incentive eligible provider category. If an eligible provider registers at the NLR and does not receive the link to the attestation system within two business days, assistance will be available by contacting the DMS Provider Enrollment Call Center Operations.

Following is a description by eligible provider type of the information that a provider will have to report or attest to during the process.

### Eligible Professional

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) (at <http://www.cms.gov/EHRIncentivePrograms/>), the EP will be asked to provide their NPI and CMS-assigned Registration Identifier.
2. The EP will then be asked to view the information that will be displayed with the pre-populated data received from the NLR (if the provider entry does not match, an error message with instructions will be returned).
3. EPs will then enter two categories of data to complete the Eligibility Provider Details screen including 1) patient volume characteristics and 2) EHR details.
4. The EP will be asked to attest to:
  - Assigning the incentive payment to a specific TIN (only asked if applicable); provider and TIN to which the payment was assigned at the NLR will be displayed;
  - Not working as a hospital based professional (this will be verified by DMS through claims analysis);
  - Not applying for an incentive payment from another state or Medicare;
  - Not applying for an incentive payment under another DMS ID; and
  - Adoption, implementation or upgrade of certified EHR technology.
5. The EP will be asked to electronically sign the amendment.
  - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify).
  - The person filling out the form should enter his or her name.

**Note:** For providers that are ready to demonstrate Meaningful Use in year 1, the provider will attest to this fact. In subsequent years, DMS will work with the KHIE to provide a mechanism for providers to submit Meaningful Use data to DMS.

## Eligible Hospital

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the EH will be asked provide:
  - Completed patient volume information on the KYSLR Web site;
  - Completed Hospital EHR Incentive Payment Worksheet;
  - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules); and
2. The EH will be asked to attest to:
  - Adoption, implementation or upgrade of certified EHR technology or meaningful use;
  - Not receiving a Medicaid incentive payment from another state; and
3. The EH will be asked to electronically sign the amendment;
  - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and
  - The person filling out the form should enter his or her name.

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the EP or EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program, EPs will only be able to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EPs or EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at <http://www.healthit.hhs.gov>). EHs can attest to either AIU or meaningful use as appropriate.

All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

## Incentive Payments

DMS plans to use the Supplemental Payment functionality in the Kentucky MMIS to set up financial transactions for incentive payments. To accomplish this, the Expenditure Panels will need be modified, and CHFS DMS will ensure this functionality is added. This will enable staff to query payments by originator. Specific accounting codes will also be required for the transactions to enable DMS to report the funds in the CMS-64 report. Different codes will be needed for each payment year.

Kentucky will ensure all reporting requirements and modifications to the MMIS are made to correctly report expenditures, attestation information, and approval information. This will include the creation of a new Management and Administrative Reporting (MAR) category of service for state and federal reporting. DMS will also make the necessary changes to the CMS-64 reporting process to add the additional line item payment and administrative information, and, if required by CMS, the Medicaid Statistical Information System (MSIS) file will be modified to accommodate the incentive payment program.

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and validation by DMS, an incentive payment can be approved.

## **Program Integrity**

DMS will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should be sure to keep their supporting documentation.

## **Administrative Appeals**

You may appeal the determination made by the Kentucky Department for Medicaid services on your incentive payment application. Please send a Formal Letter of Appeal to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or EH deems a wrong determination made by the Kentucky Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Letter of Appeal.

Division of Program Integrity  
Department for Medicaid Services  
275 E. Main Street, 6E-A  
Frankfort, KY 40621

# Registration (Eligible Providers)

Eligible providers will be required to provide details including patient volume characteristics, EHR details, upload requested documentation and electronically sign the attestation (more details follow in this manual).

After registering with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at <http://chfs.ky.gov/dms/ehr.htm> (sign-in screen shown below).

## Eligible Provider Sign-in Screen

Kentucky.gov  
KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

KY Medicaid EHR Incentive Program

User Manual  
CMS EHR Site  
KY Medicaid EHR Site  
Send E-mail

In order to receive EHR incentive payments from Kentucky Medicaid, you first have to register at the [CMS Web Site](#). After about 24 hours of successfully registering at the CMS level you should be able to complete your application on this site.

Please enter your NPI: 0123456789  
Please enter the CMS assigned Registration Identifier: \*\*\*\*\*  
Submit

The provider will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. If the data submitted by the provider matches the data received from the CMS Registration Module, the Home page for the Kentucky EHR Incentive Program will be displayed. If the provider entry does not match, an error message with instructions will be returned.

## Eligible Provider Home Screen

The Home screen will give the EP data about their current KY Attestation as well as provide navigation for the EP to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.

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CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

Home

Home/Concerns  
Reports  
Additional Resources  
User Manual  
Send E-mail

Issues/Concerns  
Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any issues and view the responses received from the CMS.  
[Click Here](#)

Provider Information  
You are currently enrolled in KY's EHR Incentive Program.  
Payment Year '2' is your current year attestation.  
The current status of your application for the year 2 payment is 'AWAITING PROVIDER ATTESTATION'.

Provider Status Flow  
CMS Registration (Completed) → Preliminary Verification (Completed) → Provider Attestation (In Progress)

Provider Attestations

Payment Year	Status	AttestationID	Action
1	Paid	KY000004	<a href="#">View</a>
2	Attest_inProcess	-	<a href="#">Begin/Modify Attestation</a>

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There are 5 sections to the Home page listed below:

1. **Messages and Announcements** – This will be the first section on the page if a message or announcement exists for the provider.
2. **Issues/Concerns** – This will be the second section on the page. The Issues / Concerns will provide a link for the provider to redirect to the Issues / Concerns page if he would like to submit a new issue or view a response to an

issue.

3. **Provider Information** – This is the third section of the home page. The provider information will give the high level status for the provider, the current payment year and the current status for the payment year.
4. **Provider Status Flow** – this is the fourth section of the home page. The Provider Status Flow will give a diagram showing the provider where he is in the current year's attestation. If the provider has been found not eligible for any reason, he will also find the specific reasons for that finding in this section.
5. **Provider Attestations** – this is the fifth section of the home page. The Provider Attestation table will list the providers attestations by payment year and list the navigation actions he has available for each.

## Eligible Provider CMS/NLR Screen

**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
PROVIDER ELIGIBILITY REGISTRATION

CMS/NLR (Year 2 Attestation)

**Provider CMS Registration Data**  
\*\*\* If any of the information is incorrect, please correct on the CMS Registration Module

Applicant National Provider Index (NPI):	2111111111	Name:	Test One
Applicant TIN:	211111111	Address 1:	1 Test Dr #110
Payee National Provider Index(NPI):	211111111	Address 2:	
Payee TIN:	211111111	City/State:	Lexington KY
Program Option:	MEACA01	Zip Code:	40507
Medicaid State:	KY	Phone Number:	8888888888
Provider Type:	Physician	Email:	testone@ky.gov
Participation Year:	2	Specialty:	Doctor of Osteopathy
Federal Exclusion:	None	State Exclusion Reason:	None

**Provider Medicaid Attestation Data**  
\*\*\* Please update the data below in reference to this attestation

**Mailing Address**

Address 1: 1 Test Dr #110  
Address 2:  
City / State: Lexington KY  
Zip Code: 40507

Medicaid Provider Type: Physician

Were you assisted by the Kentucky Regional Extension Center: ☐ Yes ☒ No

Please give the name of the person who assisted you:

Buttons: Previous, Next, Save, Cancel

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Along with the pre-populated data from the CMS Registration Module there are additional fields that can be updated by the provider.

The data provided by the CMS Registration Module is view only. If any of this data is incorrect then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected in the screen above. The fields that are from the CMS registration are listed below:

- **Applicant National Provider Index (NPI)** – This is the eligible provider's individual NPI. The NPI registered at CMS should be the same individual NPI that is enrolled in KY Medicaid.
- **Applicant TIN** – This is the Tax Identification Number that was listed in the CMS registration. This TIN should be the same TIN that is listed for the provider under KY Medicaid.
- **Payee National Provider Index (NPI)** – This is the eligible providers payee NPI given during the CMS registration. The Payee NPI given during registration should be enrolled in KY Medicaid and also a payee NPI that KY Medicaid has listed as a payee with whom the individual provider is a member.
- **Payee TIN** – The tax identification number associated with the payee NPI. This was the tax id given during registration which will have the tax liability of the incentive payment. The Payee TIN should match the FEIN or SSN listed for the payee NPI within KY Medicaid.
- **Program Option** – This is the program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.

- **Medicaid State** – This is the State that was selected during the provider’s registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS. This type will be validated with your type of license.
- **Participation year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider’s email given during the CMS registration. This email address is used for system generated emails on updates for the provider’s attestation and communication from the EHR review staff.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. Once the attestation is submitted by the provider the data will become view only. Those data fields are described below:

- **Medicaid ID**
  - This field only displays if you have multiple Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky Medicaid Numbers. **This Medicaid Number will be used to for your incentive payments.**
- **Medicaid Provider Type**
  - Please select the Medicaid type of Provider from the list provided. **This type should match the type of provider listed under your KY Medicaid enrollment and your type of license**
- **Mailing Address**
  - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence.
  - Indicating a new address in these fields will change the Payee address for the Provider’s EHR incentive payment.
- **Were you assisted by a Kentucky Regional Extension Center:**
  - Response to this question is required.
  - If the response is yes, then please type the name of the person who assisted you during the attestation process.

## Provider Eligibility Details Screen

**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
607 MEDICAL DR. INDEPENDENCE, KY 40325

Release 1.1.0

EL Admins: AT Admins: Test User: Log out

**Provider Eligibility Details (Year 1 Attestation)**

**Patient Volume:**

- Please indicate if your patient volume was calculated at a clinic or practice level for all eligible professionals.
- If yes, please enter the NPI of the clinic or group.
- For which program year are you applying?
- Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage.
- Medicaid patient encounters during this period.
- Total patient encounters during this period.
- Total number of Medicaid patients on your KenPAC or Passport roster/panel with whom you did not have an encounter in this 90-day period but you did have an encounter in the last 12 months.
- Total number of patients on your roster/panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the last 12 months.
- Medicaid patient volume percentage.

**EHR Details:**

- Enter the CMS EHR Certification ID of your EHR.
- Indicate the status of your EHR.

Previous Next Save Cancel

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EPs must enter two categories of data to complete the Eligibility Provider Details screen including patient volume characteristics and EHR details. The Provider will also have the option to change their mailing address for EHR payments. Providers will see the following data on the screen:

### ■ Patient Volume

- Please indicate if your patient volume was calculated at a clinic or practice level for all eligible professionals
- If yes, please enter the NPI of the clinic or group. Please note: KY Medicaid should have your individual NPI listed as a member of the clinic or group listed.
- Select the program year for which you are applying. An EP may attest for a given program calendar year until March 31<sup>st</sup> of the following year.
- Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage. This should be from the year prior to the program year selected.
- Medicaid patient encounters during this period
- Total patient encounters during this period
- Total number of Medicaid patients on your KenPAC or Passport roster/panel with whom you did not have an encounter in this 90-day period, but you did have an encounter in the last 12 months.  
\*\*If you are not a KenPAC or Passport Provider then enter 0 as your response.
- Total number of patients on your roster/panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the last 12 months.  
\*\*If you are not a KenPAC or Passport Provider then enter 0 as your response.
- Medicaid patient volume percentage (calculated)

### ■ EHR Details

- Enter the CMS EHR Certification ID of your EHR
- Indicate the Status of your EHR – Choices:
  - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
  - (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
  - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria

- Meaningful User – An Eligible Professional for an EHR reporting period for a payment year, demonstrates the meaningful use of a certified EHR technology by meeting the applicable objectives and measures under 42 CFR 495.6.  
 \*\*If you are attesting to Meaningful Use please see the Meaningful Use manual for EPs located at <http://chfs.ky.gov/NR/rdonlyres/2F6F44CB-C143-4BB9-8255-DD58EA8493BE/0/EPMeaningfulUseManual.pdf>

## Provider Calculations Screen

This screen displays the estimated payment for the Eligible Professional based upon the payment year and the volume calculated.

## Document Upload Screen

This screen allows the Eligible Professional to attach supporting documentation for their attestation. PDFs up to 100MB may be uploaded.

Documentation needed to process your application may be attached using the screen above. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. **Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

## Provider Attestation Screen

KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

BY MEDICARE FOR KENTUCKY PROVIDERS

Attestation (Step 5 of 5)

Logout

My Profile

My Profile Details

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

My Profile

Please verify the following information:

CMS/NLE

Applicant National Provider Identifier (NPI):	123456789	Name:	John Doe
Applicant TIN:	123456789	Address 1:	123 4th Street
Payee National Provider Identifier (NPI):	123456789	Address 2:	
Payee TIN:	123456789	City/State:	Anytown, KY
Program Option:	MSO/CAO	Zip Code:	40202
Medicaid Status:	CA	Phone Number:	502-123-4567
Payment Year:	1	Email:	john.doe@npi.com
Provider Type:	Physician	Specialty:	

Eligible Details

Patient Volume:	1. Was patient volume calculated at a clinic or practice level for all eligible professionals?	Yes
	2. If yes, Please enter the % of the clinic or group:	1
	3. I am not hospital based less than 95% of my patient encounters are at the ED or in an equivalent setting.	Y
	4. The starting date of the 90-day period to calculate Medicaid encounter volume percentage:	1/1/2018
	5. Medicaid patient encounters during this period:	120
	6. Total patient encounters during this period:	1000
	7. Total number of Medicaid patients on your network or passport roster panel with whom you did not have an encounter in the 90-day period but you did have an encounter in the last 12 months:	800
	8. Total number of patients on your roster panel from any Plan with whom you did not have an encounter in the 90-day period but you did have an encounter in the last 12 months:	1000
EHR Details:	9. Enter the CMS EHR Certification ID of your EHR:	000000123456789
	10. Indicate the status of your EHR:	<input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Non-eligible User

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to verify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments described under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State law.

All \* fields are required fields.

Initial:

NPI:

Note: Once you press the submit button below, you will not be able to change your information.

Previous Submit

The provider enters his/her initials and NPI on the bottom of the Attestation Screen to complete the Kentucky Medicaid EHR Incentive Program Attestation process. By completing this step of the registration process, the provider will have attested to the validity of all data submitted for consideration by the Kentucky Medicaid EHR Incentive Program. Once the provider submits this data on the screen, the registration process is completed, and the provider may logout of the application.

## Registration (Eligible Hospitals)

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>.

The hospital provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at <http://chfs.ky.gov/dms/ehr.htm> (sign-in screen shown below) and entering the NPI and CMS-assigned registration identifier that was received from CMS.

### Eligible Hospital Sign-in Screen

The provider will enter the NPI registered on the CMS Registration Module and the CMS-assigned Registration Identifier that was returned by the CMS registration. If the data submitted by the provider matches the data received from the CMS Registration Module, the Home page for the Kentucky EHR Incentive Program will be displayed. If the provider entry does not match, an error message with instructions will be returned.

### Eligible Provider Home Screen

The Home screen will give the EH data about their current KY Attestation as well as provide navigation for the EH to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.

Payment Year	Status	AttestationID	Action
1	Paid	8Y0000084	<a href="#">View</a>
2	Attest_inProcess		<a href="#">Begin/Modify Attestation</a>

There are 5 sections to the Home page listed below:

1. **Messages and Announcements** – This will be the first section on the page if a message or announcement exists for the provider.
2. **Issues/Concerns** – This will be the second section on the page. The Issues / Concerns will provide a link for the provider to redirect to the Issues / Concerns page if he would like to submit a new issue or view a response to an issue.
3. **Provider Information** – This is the third section of the home page. The provider information will give the high level status for the provider, the current payment year and the current status for the payment year.
4. **Provider Status Flow** – this is the fourth section of the home page. The Provider Status Flow will give a diagram showing the provider where he is in the current year's attestation. If the provider has been found not eligible for any reason, he will also find the specific reasons for that finding in this section.
5. **Provider Attestations** – this is the fifth section of the home page. The Provider Attestation table will list the providers attestations by payment year and list the navigation actions he has available for each.

## Eligible Hospital CMS/NLR Screen

**Provider CMS Registration Data**

\*\*\* If any of the information is incorrect, please contact the CMS Registration Module

Applicant National Provider Index (NPI):	777777777	Name:	TEST 2HR HOSPITAL
Applicant TIN:	77777777	Address 1:	1000 Ave.
Payee National Provider Index (NPI):		Address 2:	
Payee TIN:		City/State:	Covington, KY
Program Option:	DUALYX_ELIGIBLE	Zip Code:	40303-1501
Medicaid Status:	KY	Phone Number:	5028440000
Provider Type:	Acute_Care_Hospital	Email:	test@admission@ky.gov
Participation Year:	2	Specialty:	CRITICAL ACCESS HOSPITAL
Federal Exclusions:	None	State Rejection Reason:	None

**Provider Medicaid Attestation Data**

\*\*\* Please update the data below in reference to the attestation

**Mailing Address**

Address 1: 1000 Ave

Address 2:

City / State: Covington, KY

Zip Code: 40303

Medicaid ID: 777777777

Were you visited by the Kentucky Regional Intensive Center? ☐ Yes ☒ No

Please give the name of the person who visited you:

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Along with the pre-populated data from the CMS Registration Module there are additional fields that can be updated by the provider.

The data provided by the CMS Registration Module is view only. If any of this data is incorrect then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected in the screen above. The fields that are from the CMS registration are listed below:

- **Applicant National Provider Index (NPI)** – This is the eligible hospital or CAH's registering NPI. The NPI registered at CMS should be the same NPI that is enrolled in KY Medicaid.
- **Applicant TIN** – This is the Tax Identification Number that was listed in the CMS registration. This TIN should be the same TIN that is listed for the provider under KY Medicaid.
- **Payee National Provider Index (NPI)** – This is the payee NPI given during the CMS registration.
- **Payee TIN** – The tax identification number associated with the payee NPI.
- **Program Option** – This is the program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.

- **Medicaid State** – This is the State that was selected during the provider’s registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS.
- **Participation year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider’s email given during the CMS registration. This email address is used for system generated emails on updates for the provider’s attestation and communication from the EHR review staff.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. Once the attestation is submitted by the provider the data will become view only. Those data fields are described below:

- **Medicaid ID**
  - This field only displays if you have multiple Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky Medicaid Numbers. **This Medicaid Number will be used to for your incentive payments.**
- **Mailing Address**
  - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence.
  - Indicating a new address in these fields will change the Payee address for the Provider’s EHR incentive payment.
- **Were you assisted by a Kentucky Regional Extension Center:**
  - Response to this question is required.
  - If the response is yes, then please type the name of the person who assisted you during the attestation process.

## Hospital Eligibility Details Screen

Hospital Eligibility Details (Year 1 Attestation)

All \* fields are required fields.

Patient Volume:	1. For which program year are you applying?	* 2012
	2. Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:	* 5/5/2011 (mm/dd/yy)
	3.(f) Medicaid Inpatient Discharges during this period:	* 5
	(g) Medicaid ER/other Discharges (requires attestation):	* 5
	(h) Total Medicaid patient discharges during this period:	* 10
	4. Total patient discharges during this period:	* 11
	5. Medicaid patient volume percentage:	90.91%
EHR Details:	6. Enter the CMS EHR Certification ID of your EHR:	* <input type="text"/> <a href="#">What is this?</a>
	7. Indicate the status of your EHR:	* <input type="radio"/> Adopt <input checked="" type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User
Growth Rate:	8. Select the end date of the hospital's most recently filed 12-month cost reporting period:	* 5/5/2011 (mm/dd/yy)
	9. Total number of discharges that fiscal year:	* 10 (w/s 5-3, part I, col. 15, line 14)
	10. Total number of discharges one year prior:	* 20
	11. Total number of discharges two years prior:	* 30
	12. Total number of discharges three years prior:	* 10
Medicaid Share:	13. Total Medicaid inpatient bed days (Exclude Nursery beds):	* 15 (w/s 5-3, part I, col. 7, line 14)
	14. Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	* 18 (w/s 5-3, part I, col. 7, line 2)
	15. Total inpatient bed days:	* 50 (w/s 5-3, part I, col. 8, line 14)
	16. Total hospital charges:	* 10.00 (w/s c part I, col. 8, line 202)
	17. Total uncompensated care charges:	* 7.00 (KMAP-4, line 4)

As shown above, hospitals must enter four categories of data to complete the Eligibility Details screen including patient volume characteristics, EHR details, growth rate, and Medicaid share. Providers will enter the following data on the screen:

### ■ Patient volume

- Select the program year for which you are applying. An EH may attest for a given program year until the December 31<sup>st</sup> following the end of that Federal Fiscal Year(10/1 – 9/30).
- Starting date of the 90-day period to calculate Medicaid patient volume percentage. This should be a 90 day period that is within the Federal Fiscal year prior to the one selected as the program year.
- Total Medicaid Inpatient Discharges during this period
- Total Medicaid ER/Other Discharges during this period
- Total Medicaid patient discharges during this period – Automatically calculated by adding the 2 entries above.
- Total patient discharges during the period
- Medicaid patient volume percentage (calculated)

### ■ EHR details

- EHR certification ID of EHR
- Status of your EHR – Choices:
  - **(A) Adopt** - Acquire, purchase, or secure access to certified EHR technology
  - **(I) Implement** - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
  - **(U) Upgrade** - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
  - **Meaningful User** – An Eligible Hospital or CAH, for an EHR reporting period for a payment year, demonstrates the meaningful use of a certified EHR technology by meeting the applicable objectives and measures under 42 CFR 495.6.

\*\*If you are attesting to Meaningful Use please see the Meaningful Use manual for EHs located at

- **Growth rate**
  - End date of the hospital's most recently filed 12-month cost reporting period
  - Total number of discharges that fiscal year - (w/s S-3 part I, col. 15, line 14)
  - Total number of discharges one year prior
  - Total number of discharges two years prior
  - Total number of discharges three years prior
  - Average annual growth rate (calculated)
- **Medicaid share**
  - Total Medicaid inpatient bed days excluding Nursery Bed days - (w/s S-3 part I, col. 7, line 14)
  - Total Medicaid Health Maintenance Organization (HMO) inpatient bed days excluding Nursery Bed days - (w/s S-3 part I, col. 7, line 2)
  - Total inpatient bed days (Please note per CMS FAQ nursery days are excluded from inpatient bed days) - (w/s S-3 part I, col. 8, line 14)
  - Total hospital charges - (w/s c part I, col. 8 line 202)
  - Total uncompensated care charges , this line includes inpatient and outpatient uncompensated care charges
    - KMAP 4 line 4 for is used for the inpatient uncompensated care charges and supporting documentation for outpatient uncompensated care charges should be attached using the document upload screen
  - Estimated total payment (calculated)

## Eligibility Incentive Payment Calculations Screen

**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
BY MEDICAID ESTABLISHED 1993

**Incentive Payment Calculations** Logout

CM/HR  
Eligibility Details  
Payments  
News/Contact  
Reports  
User Manual  
Additional Resources  
Send Email

**Patient Volume Calculations**

Medicaid Patient Volume Percentage: 50.00% \* should be greater than 10% to qualify

Rate of growth prior year: 1.334%

Rate of growth 2 years prior: 1.918%

Rate of growth 3 years prior: 4.877%

Average rate of growth: 2.606% \* use this growth rate to project number of discharges for year 2 through year 4 below

**EHR Amount Calculations**

	Year	Discharges	Allowable Discharges	Discharge Related Amount	Base Amount	Aggregate EHR amount	Transition Factor	EHR Amount
First year	2010	29350	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	1.00	\$6,370,200.00
Second Year	2009	29990	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.75	\$4,777,650.00
Third Year	2008	20667	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.50	\$3,185,100.00
Fourth Year	2007	27362	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.25	\$1,592,550.00
Total Amount								\$15,925,500.00

**Medicaid Share Calculations**

Total Medicaid and Passport Inpatient bed Days: 8291

Total bed Days: 132145

Percentage of total charges which are non-charity (total charges - uncompensated charges/ total charges): 99.66%

Total beds that should be considered non-charity: 131896

Total Medicaid Percentage: 4.73135%

Total Medicaid Aggregate EHR Incentive Payment: \$751,491.30

Total Estimated Medicaid Aggregate EHR Incentive Payment: \$376,745.66

First Year (2015):

Previous Next

This screen displays the estimated payment for the Eligible Hospital based upon the payment year and the volume calculated.

## Document Upload Screen

Kentucky.gov Release 1.18 KY Agencies - KY Services Test User

**KENTUCKY**  
CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

Document Upload (Year 1 Attestation) Logout

CMS/NUR  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
User Manual  
Send Email

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. **Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

Payment Year	File Name	Description
No uploaded document found.		

Upload a new PDF document:

Browse...

Upload

Please select the documentation type:

--Select the type of a document--

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This screen allows the Eligible Professional to attach supporting documentation for their attestation. PDFs up to 100MB may be uploaded.

Documentation needed to process your application may be attached using the screen above. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. **Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

After EPs and EHs have completed the Eligibility Details screens and press “Next,” navigation will take them to the Attestation screen below.

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES <small>BE BOLD • BE BETTER • BELIEVE</small>		Attention (Step 4 of 4)		<a href="#">Logout</a>
<a href="#">CMS/RLE</a> <a href="#">Eligibility Details</a> <a href="#">Applicant</a> <a href="#">HMAC/Certains</a> <a href="#">Approval</a> <a href="#">DRG Manual</a> <a href="#">Additional Resources</a> <a href="#">Print &amp; Mail</a>				
<b>CMS/RLE</b>				
Approved National Provider Index (NPI)	012450798	Name	Denn Hospital	
Approved TIN	012450798	Address 1	110 Any Street	
Payer National Provider Index (NPI)	012450798	Address 2		
Payer TIN	012450798	City/State	Anytown / KY	
Program Status	INALLY-PT008-B	Zip Code	40000 -	
Hospital State	KY	Phone Number	(502) 123-4567	
Payment Type	1	Email	denn.hospital@denn.org	
Provider Type	Acute Care Hospital	Specialty		
<b>Hospital Eligibility Details:</b>				
Patient Volume:	1.	Select the starting date (in YYYY or YY format) to calculate Medicaid patient volume percentage.	5/6/2010 (YYYY/MMYY)	
	2.	Total Inpatient patient discharges during this period.	300	
	3.	Total patient discharges during this period.	300	
DRG Details:	4.	Enter the DRG certification number of your state.	000000110VJBLAK	
	5.	Indicate the status of your DRG.	<input checked="" type="radio"/> Admitt <input type="radio"/> Amend <input type="radio"/> Upgrade <input type="radio"/> Reassigned code	
Discharge Rate:	6.	Select the end date of your last full hospital fiscal year that ended prior to September 30, 2015.	5/5/2012 (MM/DD/YYYY)	
	7.	Total number of discharges that fiscal year.	15100 (only 1-9 part 1, no 0, less 10)	
	8.	Total number of discharges one year prior.	14889	
	9.	Total number of discharges two years prior.	14654	
	10.	Total number of discharges three years prior.	14456	
	11.	Total Inpatient Inpatient bed days (Exclude Maternity beds).	6221	
	12.	Total Inpatient IMUD Inpatient bed days (Exclude Maternity beds).	0	
Medicaid Share:	13.	Total Inpatient bed days.	151140	
	14.	Total Inpatient charges.	\$157,979,000 (only 1 part 1, no \$, less 000)	
	15.	Total uncompensated care charges.	\$1,400,000 (MMP-4, line 4)	
	16.			
<p>I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid Incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.</p> <p>This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid DRG incentive payment(s) submitted under this provider number will be from Federal funds, and that any Modification or revocation of a material fact may be prosecuted under Federal and State laws.</p>				
Details	<input type="text" value="012450798"/> <input type="text" value="012450798"/>			
Note: Once you press the submit button below, you will not be able to change your information.				
<input type="button" value="Previous"/>		<input type="button" value="Submit"/>		

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## Issues/Concerns Screen

Kentucky.gov  
KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

Issues/Concerns Logout

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If you have any issue with the determination of your incentive payment application including but not limited to Eligibility, Patient volume or Payment Amount, you can notify us using the form below. Please be further advised that you also have access to a formal appeal process.

Issues/Concerns List:

View Issue	Date Entered	Issue/Concern Status	Issue/Concern Description	Issue Category
Select	2/15/2011 4:55:40 PM	Open	Am I eligible for th...	Eligibility

Resolved Issues/Concerns List:

Issue/Concern Response	Responded By	Date Responded	Issue/Concern Status	Issue Category
Payment done! please...	harika.reddy	2/15/2011 4:53:43 PM	Resolved	Payment Amount
That's good.	harika.reddy	2/15/2011 4:54:32 PM	Resolved	Patient Volume

Enter the issue/Concern below:

Issue Category:

Description:

Submit

User can open an issue and click submit.

## Appeals Screen

Kentucky.gov Release 1.18 KY Agencies KY Services  
KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
KY MEDICAID EHR INCENTIVE PAYMENTS

TEST EHR HOSPITAL

Appeals (Year 1 Attestation) Logout

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You may appeal the determination made by the Kentucky Department for Medicaid services on your incentive payment application. Please send a Formal Letter of Appeal to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or Hospital deems a wrong determination was made by the Kentucky Medicaid EHR Incentive Program. The EP or Hospital will need to submit any supporting documentation to their appeal with the Letter of Appeal.

Division of Program Integrity  
Department for Medicaid Services  
275 E. Main Street, 6E-A  
Frankfort, KY 40621

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The appeals screen provides information on how to appeal and the contact information for sending in an official appeal of an EP or EH attestation.

## Meaningful Use

Please see the Meaningful Use manuals for EP and EH for information specific to attesting for Meaningful Use. The Links for these manuals are listed below. You may also find additional information on Core and Menu Measure details at the CMS sites listed below:

- Eligible Hospital Meaningful Use Manual – <http://chfs.ky.gov/NR/rdonlyres/C44564E4-1D21-45EB-9C94-770B4BEB2AF3/0/EHMeaningfulUseManual.pdf>
- Eligible Professional Meaningful Use Manual - <http://chfs.ky.gov/NR/rdonlyres/2F6F44CB-C143-4BB9-8255-DD58EA8493BE/0/EPMeaningfulUseManual.pdf>
- **EP Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet Meaningful Use measure per Measure. Provides Definitions and FAQs per measure. - <http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>
- **EH/CAH Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet Meaningful Use measure per Measure. Provides Definitions and FAQs per measure. - [http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp\\_CAH\\_MU-TOC.pdf](http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf)